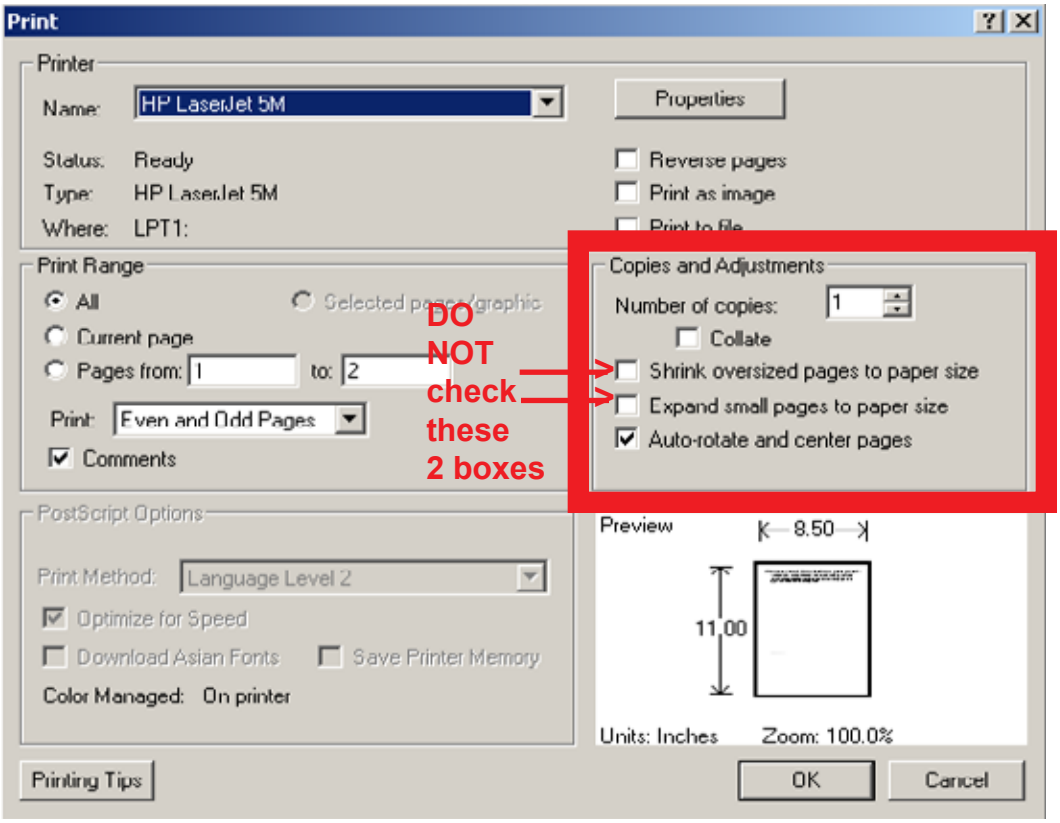
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand



DOH 600-033 (3/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Conscious Sedation With Parenteral Or Multiple Oral Agents And/Or General Anesthesia/Deep Sedation Permit Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Conscious Sedation/General Anesthesia Permit—Dentistry

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 646-142 (Rev. 3/2006)

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Health Professions Quality Assurance
Dental Quality Assurance Commission
P.O. Box 47867
Olympia, WA 98504-7867

Application For A Conscious Sedation With Parenteral Or Multiple Oral Agents And/Or General Anesthesia/ Deep Sedation Permit

General Instructions

Please complete the enclosed application and submit proof of your qualification and any other documentation required as stated on the application form.

The permit fee is $50.00. **(This fee is non-refundable.)** The check or money order should be made payable to the **Washington State Department of Health** and submitted with the application to the following address:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Should you have any questions regarding the application or the requirements, please contact: (360) 236-4822.

Applicants for general anesthesia permits*:* prior to issuance of a general anesthesia permit, an on-site inspection must be conducted at all practice locations where you will be administering anesthesia. **Inspections may be conducted by yourself or by a peer.**

Mobile Anesthesia Services: A completed inspection form must be submitted for each facility where anesthesia services are provided.

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

For Office Use Only	
CERTIFICATION#:	DATE ISSUED:

CERTIFICATE #

Application For A Conscious Sedation With Parenteral Or Multiple Oral Agents And/Or General Anesthesia/Deep Sedation Permit Dentistry

☐ Conscious Sedation With Parenteral or Multiple Oral Agents
☐ General Anesthesia/Deep Sedation and Conscious Sedation with Parenteral or Multiple Oral Agents

Please Type or Print Clearly—Follow carefully all instructions provided in the general instructions. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is nonrefundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME | LAST | FIRST | MIDDLE INITIAL

ADDRESS OF PRIMARY PRACTICE

CITY | STATE | ZIP | COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)
( )

RESIDENCE TELEPHONE
( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
– –

Type of Practice: ☐ General ☐ Oral Surgery ☐ Other (specify) _____

2. Previous Licensure or Certification

List all states where certificate(s) or licenses are or were held. (Previous credential to include license, certification or registration.) Specifically list certificate(s) or licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if certificate or license is current. If licensed in more than four states, please indicate on separate sheet.

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YR ISSUED	NUMBER		EXAM	OTHER	
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. Method of Qualification

Yes No

Conscious Sedation Permit With Parenteral or Multiple Oral Agents Permit

Indicate under which method below you qualify for a conscious sedation with parenteral or multiple oral agents permit. **Attach documented proof of your post-doctoral qualification. This must include hours and patients.**

Completed a postdoctoral course(s) of **sixty clock hours or more** which includes training in basic conscious sedation, physical evaluation, venipuncture, technical administration, recognition and management of complications and emergencies, monitoring and supervised experience in providing conscious sedation to **fifteen or more patients**. ☐ ☐

List course(s) taken, course sponsor, dates attended, and course hours. _____

_____

_____

Facilities and Equipment Requirements for Conscious Sedation with Parenteral or Multiple Oral Agents

Do you provide the following:

1. Suction equipment capable of aspirating gastric contents from the mouth and pharynx? ☐ ☐
2. A portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen-enriched ventilation and oral and nasal pharyngeal airways of appropriate size? ☐ ☐
3. A blood pressure cuff (sphygmomanometer) of appropriate size and stethoscope; or equivalent monitoring devices? ☐ ☐
   Please indicate what the equivalent monitoring device is including make, model, and serial #: _____
4. A pulse oximeter? (Must list make, model and serial number. Use the space below.) ☐ ☐

_____

Drug and Equipment for Conscious Sedation with Parenteral or Multiple Oral Agents

1. Do you have an emergency kit with minimum contents of the following: ☐ ☐

- Sterile needles, syringes and tourniquet
- Narcotic antagonist
- A and B adrenergic stimulant
- Vasopressor
- Coronary vasodilator
- Antihistamine
- Parasympatholytic
- Intravenous fluids, tubing and infusion set
- Sedative antagonists for drugs used if available

Records for Conscious Sedation with Parenteral or Multiple Oral Agents

Do you maintain records in the following manner:

1. Appropriate medical history and patient evaluation. Dosage and forms of medications dispensed are noted. ☐ ☐
2. The pulse, respiration and blood pressure and/or blood oxygen saturation noted and recorded whenever possible prior to the procedure unless prevented by the patient's physical or emotional condition. ☐ ☐
3. The pulse, respiration and blood pressure and/or bloody oxygen saturation noted and recorded at the conclusion of the procedure. ☐ ☐
4. Blood oxygen saturation continuously monitored and recorded at appropriate intervals throughout any period of time in which purposeful response of the patient to verbal command cannot be maintained. ☐ ☐
5. The patient's level of consciousness recorded prior to the dismissal of the patient. ☐ ☐

Provide a list of addresses of all locations of practice utilizing conscious sedation with parenteral or multiple oral agents:

_____

_____

_____

General Anesthesia / Deep Sedation Permit

Indicate below under which you qualify for general anesthesia/deep sedation permit. **Attach documented proof of your qualification.**

☐ Completed a minimum of one year's advanced training in anesthesiology or related academic subjects, or its equivalent beyond the undergraduate dental school level, in a training program as outlined in Part 2 of Teaching the Comprehensive Control of Pain and Anxiety in an Advanced Education Program, published by the American Dental Association, Council on Dental Education, dated July 1993.

List program and dates attended. _____

☐ Am a Fellow of the American Dental Society of Anesthesiology

☐ Am a Diplomate of the American Board of Oral and Maxillofacial Surgery, or am eligible for examination by the American Board of Oral and Maxillofacial Surgery pursuant to the July 1, 1989, standards.

☐ Am a Fellow of the American Association of Oral and Maxillofacial Surgery

Please indicate yes or no to the right: **Yes No**

1. I hold a current certificate in Advanced Cardiac Life Support or equivalent. (Please explain equivalent on separate sheet of paper.) ..... ☐ ☐
2. In addition to those individuals necessary to assist me in performing the procedure, I do have a trained individual to be present to monitor the patient's cardiac and respiratory functions. This individual monitoring patients receiving deep sedation or general anesthesia has received a minimum of fourteen hours of documented training in a course specifically designed to include instruction and practical experience in use of all equipment required in WAC 246-817-770. This must include, but not be limited to, the following equipment: ..... ☐ ☐

- Sphygmomanometer
- Pulse oximeter
- Electrocardiogram
- Bag-valve-mask resuscitation equipment
- Oral and nasopharyngeal airways
- Defibrillator
- Intravenous fluids administration set

Facilities and Equipment Requirements for General Anesthesia / Deep Sedation

Do you provide the following:

1. An operating theater large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient? ..... ☐ ☐
2. An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, provide a firm platform for the administration of basic life support? ..... ☐ ☐
3. A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any operation underway at the time of general power failure? ..... ☐ ☐
4. Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities and a backup suction device? ..... ☐ ☐
5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system? ..... ☐ ☐

   List serial number _____

   Manufacturer _____ Model Number _____
6. A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating theater. During the recovery phase the patient is monitored continually by an individual trained to monitor patients recovering from general anesthesia or deep sedation. ..... ☐ ☐
7. Ancillary equipment, which must include **all** of the following: ..... ☐ ☐

- Laryngoscope complete with adequate spare batteries and bulb
- Endotracheal tubes with appropriate connectors
- Oral airways
- Tonsillar or pharyngeal suction tip adaptable to all office outlets
- Endotracheal tube forceps
- Sphygmomanometer and stethoscope
- Adequate equipment to establish an intravenous infusion
- Pulse oximeter
- Electrocardiographic monitor
- Synchronized defibrillator available on premises

Drugs for General Anesthesia / Deep Sedation

	Yes	No
Are all of the following emergency drugs available in your facility:	☐	☐

- Vasopressor
- Corticosteroid
- Bronchodilator
- Muscle relaxant
- Intravenous medications for treatment of cardiac arrest
- Narcotic antagonist, Sedative antagonist, if available
- Antihistaminic
- Anticholinergic
- Antiarrhythmic
- Coronary artery vasodilator
- Antihypertensive
- Anticonvulsant

Records for General Anesthesia / Deep Sedation

Do you maintain records in the following manner:

1.	Appropriate medical history and patient evaluation records.	☐	☐
2.	Anesthesia records recorded during the procedure in a timely manner and must include: blood pressure, heart rate, respiration, blood oxygen saturation, drugs administered including amounts and time administered, length of procedure, any complications of anesthesia. (The patient's blood pressure, heart rate, and respiration is recorded at least every five minutes.)	☐	☐
3.	A discharge entry made in the patient's record indicating the patient's condition upon discharge and the responsible party to whom the patient was discharged.	☐	☐

Provide a list of addresses of **all locations** of practice utilizing general anesthesia/deep sedation: (excluding hospital and surgery center locations):

_____

_____

_____

5. Applicant's Attestation

I, _____ (Name of Applicant), certify that I am the person described and identified in this application; that I have read RCW 18.32, WAC 246-817, and RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

Signature of Applicant _____ Date _____

State Seal

Subscribed and sworn to before me this _____ day of _____ , 20 ____ .

Notary in and for the State of _____

Residing at _____

Signature of Notary _____

My Commission Expires _____

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

General Anesthesia On-site Inspection And Evaluation Form

Name of Practitioner:

Location/Address Inspected:	
Additional Office Locations and/or Sites where anesthesia services are performed (attach additional sheet if necessary):	
General Anesthesia Permit Number:	Telephone Number at Location Evaluated:
Date of Evaluation:	Time:
Name of Evaluator(s):	

A. Personnel

	Yes	No
1) Valid ACLS Certificate of Equivalent (Please have Dr.'s ACLS Certification available)	☐	☐
2) Evidence of:		
a. 1 year advanced training in anesthesiology or Fellow of the American Dental Society of Anesthesiology	☐	☐
b. Diplomat of American Board of Oral and Maxillofacial Surgery or	☐	☐
c. Eligible for examination by American Board of Oral and Maxillofacial Surgery or	☐	☐
d. Fellow of the American Association of Oral and Maxillofacial Surgery.	☐	☐
3) List assisting staff's credentials/CV/training: (Attach documentation.)		
a. _____		
b. _____		
c. _____		
4) Evidence that monitoring personnel have a certificate of adequate training under WAC 246-817-770(1). **(Attach documentation.)**	☐	☐

B. Records

Have available three (3) charts of patients who have been treated in your office with IV sedation or general anesthesia.

1) An adequate medical history of the patient.	☐	☐

	Yes	No
2) An adequate physical evaluation of the patient.	☐	☐
3) Anesthesia Records showing:	☐	☐
Continual monitoring of heart rate, blood pressure, respiration and oximetry. These should be recorded every 5 minutes.		
4) Evidence of continual recovery monitoring with a notation of patient's condition upon discharge and to whom patient was discharged.	☐	☐
5) Accurate recording of mediations administered including amounts and time administered.	☐	☐
6) Records illustrating length of procedure.	☐	☐
7) Records reflecting any complications of anesthesia.	☐	☐

C. Office Facility And Equipment

(Make a list of (a) brand name/type of equipment and (b) serial numbers.)

BP/Dynamap a. _____

b. _____

EKG a. _____

b. _____

Defibrillator a. _____

b. _____

Oximeter a. _____

b. _____

	Yes	No
1) Operating Theater		
a. Is the operating theater large enough to adequately accommodate the patient on a table or in an operating chair?	☐	☐
b. Does the operating theater permit an operating team consisting of at least three individuals to freely move about the patient?	☐	☐
2) Operating Chair or Table		
a. Does the operating chair or table permit the patient to be positioned so the operating team can maintain the airway?	☐	☐
b. Does the operating chair or table permit the team to quickly alter the patient's position in an emergency?	☐	☐
c. Does the operating chair or table provide a firm platform for the management of CPR?	☐	☐
3) Lighting System		
a. Does the lighting system permit evaluation of the patient's skin and mucosal color?	☐	☐
b. Is there a battery powered backup lighting system?	☐	☐

	Yes	No
c. Is the backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?	☐	☐
4) Suction Equipment		
a. Does the suction equipment permit aspiration of the oral and pharyngeal cavities?	☐	☐
b. Is there a backup suction device available?	☐	☐
5) Oxygen Delivery System		
a. Does the oxygen delivery system have adequate full face masks and appropriate connectors and is it capable of delivering oxygen to the patient under positive pressure?	☐	☐
b. Is there an adequate backup oxygen delivery system?	☐	☐
6) Recovery Area (Recovery Area can be the operating theater)		
a. Does the recovery area have available oxygen?	☐	☐
b. Does the recovery area have adequate suction available?	☐	☐
c. Does the recovery area have adequate lighting?	☐	☐
d. Does the recovery area have adequate electrical outlets?	☐	☐
e. In accordance with WAC 246-817-770(2), can the patient be observed by a member of the staff at all times during the recovery period?	☐	☐
7) Ancillary Equipment		
a. Is there a working laryngoscope complete with an adequate selection of blades, spare batteries and bulbs?	☐	☐
b. Are there endotracheal tubes and appropriate connectors?	☐	☐
c. there a backup suction device available?	☐	☐
d. Is there a tonsillar or pharyngeal type suction tip adaptable to all office outlets?	☐	☐
e. Are there endotracheal tube forceps?	☐	☐
f. Is there a sphygmomanometer and stethoscope?	☐	☐
g. Is there a pulse oximeter?	☐	☐
h. Is there an electrocardioscope and defibrillator?	☐	☐
i. Is there adequate equipment for the establishment of an intravenous infusion?	☐	☐

D. Drugs

1) Vasopressor drug available?	☐	☐
2) Corticosteroid drug available?	☐	☐
3) Bronchodilator drug available?	☐	☐
4) Muscle relaxant drug available?	☐	☐
5) Intravenous medication for treatment of cardiopulmonary arrest?	☐	☐

	Yes	No
6) Narcotic antagonist drug available?	☐	☐
7) Antihistaminic drug available?	☐	☐
8) Antiarrhythmic drug available?	☐	☐
9) Anticholinergic drug available?	☐	☐
10) Coronary artery vasodilator drug available?	☐	☐
11) Antihypertensive drug available?	☐	☐

Overall Equipment/Facility: ☐ Adequate ☐ Inadequate

Comments:

Recommendations:

Signature of Evaluators/Date: Print Name:

Affidavit for practitioners providing anesthesia services at multiple site locations:

"I hereby attest that **all sites** or facilities in which I perform general anesthesia services meet the criteria indicated in this inspection form. (A separate survey form may be completed in lieu of signing this affidavit.)"

Signature Date

Signature of Practitioners Evaluated/Date: Print Name:

Washington Administrative Code (WAC) Relating to Conscious Sedation/General Anesthesia

WAC 246-817-170 Applications—Permits—Renewals for the administration of conscious sedation with multiple oral or parenteral agents or general anesthesia (including deep sedation). (1) To administer conscious sedation with parenteral or multiple oral agents or general anesthesia (including deep sedation), a dentist must first meet the requirements of this chapter, possess and maintain a current license pursuant to chapter 18.32 RCW and obtain a permit of authorization from the DQAC through the department. Application forms for permits, which may be obtained from the department, shall be fully completed and include the application fee.

(2) To renew a permit of authorization, which is valid for three years from the date of issuance, a permit holder shall fully and timely complete a renewal application form and:

(a) Demonstrate continuing compliance with this chapter.

(b) Produce satisfactory evidence of eighteen hours of continuing education as required by this chapter. The dentist must maintain records that can be audited and must submit course titles, instructors, dates attended, sponsors, and number of hours for each course every three years as required by this chapter.

(c) Pay any applicable renewal fee.

(3) Prior to the issuance or renewal of a permit for the use of general anesthesia, the DQAC may, at its discretion, require an on-site inspection and evaluation of the facility, equipment, personnel, licensee, and the procedures utilized by such licensee. Every person issued a permit under this article shall have an on-site inspection at least once in every five-year period, or at other intervals determined by the DQAC. An on-site inspection performed by a public or private organization may be accepted by the DQAC to satisfy the requirements of this section.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-170, filed 10/10/95, effective 11/10/95.]

WAC 246-817-175 Conscious sedation with parenteral or multiple oral agents—Education and training requirements—Application. (1) To obtain a permit of authorization to administer conscious sedation with parenteral or multiple oral agents, the dentist shall meet the requirements of subsection (2) of this section and submit an application and fee. Applications may be obtained from the dental HPQA division.

(2) Training requirements: To administer conscious sedation with parenteral or multiple oral agents, the dentist must have successfully completed a postdoctoral course(s) of sixty clock hours or more which includes training in basic conscious sedation, physical evaluation, venipuncture, technical administration, recognition and management of complications and emergencies, monitoring, and supervised experience in providing conscious sedation to fifteen or more patients.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-175, filed 10/10/95, effective 11/10/95.]

WAC 246-817-180 General anesthesia (including deep sedation)—Education and training requirements. (1) Training requirements for dentists: To administer deep sedation or general anesthesia, the dentist must have current and documented proficiency in advanced cardiac life support. One method of demonstrating such proficiency is to hold a valid and current ACLS certificate or equivalent. A dentist must also meet one or more of the following criteria:

(a) Have completed a minimum of one year's advanced training in anesthesiology or related academic subjects, or its equivalent beyond the undergraduate dental school level, in a training program as outlined in Part 2 of Teaching the Comprehensive Control of Pain and Anxiety in an Advanced Education Program, published by the American Dental Association, Council on Dental Education, dated July 1993.

(b) Is a fellow of the American Dental Society of Anesthesiology.

(c) Is a diplomate of the American Board of Oral and Maxillofacial Surgery, or is eligible for examination by the American Board of Oral and Maxillofacial Surgery pursuant to the July 1, 1989, standards.

(d) Is a fellow of the American Association of Oral and Maxillofacial Surgeons.

(2) Only a dentist meeting the above criteria for administration of deep sedation or general anesthesia may utilize the services of a nurse licensed pursuant to chapter 18.79 RCW to administer deep sedation or general anesthesia under the close supervision of the dentist as defined in WAC 246-817-510.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-180, filed 10/10/95, effective 11/10/95.]